ACOG District II
Opioid Use Disorder in Pregnancy Bundle – Part 1
Readiness, Recognition and Prevention

Revised March 2019

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Disclaimers: The following material is an example only and not meant to be prescriptive. ACOG accepts no liability for the content or consequences of any actions taken on the basis of the information provided.

- This education is not exclusive to maternal opioid use disorder (OUD). The management approaches outlined within may also be effective in helping women with other substance use disorders.
- Each clinical setting must take into account the resources available within its own institution and community. Practices and institutions are strongly encouraged to review their existing policies and procedures for OUD in pregnancy management and modify them if necessary to maximize safe patient care.
Opioid Use Disorder in Pregnancy Bundle

Purpose

• Offer multi-faceted education and implementation tools to better assist women’s health care providers in caring for pregnant women with OUD
• Encourage better communication and engagement among providers across all of the services within the continuum of care, including the justice system
• Enhance the communication of OUD through the use of a common language
• Enhance patient and family engagement through education, common language; understand treatment and process
Opioid Use Disorder in Pregnancy: Know the Basics

First Steps
Physical Opioid Dependence

“Physical dependence is the physiological adaptation of the body to the presence of an opioid. It is defined by the development of withdrawal symptoms when opioids are discontinued, when the dose is reduced abruptly or when an antagonist (eg, naloxone) or an agonist-antagonist (eg, pentazocine) is administered.”


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Opioid Addiction

• **Primary chronic disease** of brain reward, motivation, memory and related circuitry.
  - Dysfunction in these circuits leads to psychological, social, and spiritual manifestations.
• Reflected in an individual pathologically pursuing reward and/or relief by opioid use and other behaviors.
• Like other chronic diseases, addiction often involves cycles of relapse and remission.
• Without treatment, addiction is progressive and can result in disability or death.


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Addiction and Other Chronic Conditions

Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses

- Drug Addiction: 40-60%
- Type 2 Diabetes: 30-50%
- Hypertension: 50-70%
- Asthma: 50-70%

Source: JAMA 284: 1689-1695, 2000
Substance Use Disorders (SUDs)

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home.

- Alcohol Use Disorder (AUD)
- Opioid Use Disorder (OUD)
- Stimulant Use Disorder
- Hallucinogen Use Disorder (HUD)
- Tobacco Use Disorder
- Cannabis Use Disorder

Source: SAMHSA; https://www.samhsa.gov/disorders/substance-use
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
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Opioid Use Disorder (OUD)

Opioid use disorder is a chronic, treatable brain disease that can be managed successfully by combining medications with comprehensive care and recovery support, which enables those with OUD to regain control of their health and their lives.

In 2014, an estimated 1.9 million people had an OUD related to prescription pain relievers and an estimated 586,000 had an OUD related to heroin use.

Sources: SAMHSA; https://www.samhsa.gov/disorders/substance-use
DSM-V Diagnostic Criteria: OUD & SUD

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6 or more is severe.

- Taking the opioid in larger amounts and for longer than intended
- Wanting to cut down or quit but not being able to do it
- Spending a lot of time obtaining the opioid
- Craving or a strong desire to use opioids
- Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Recurrent use of opioids in physically hazardous situations
- Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids

*Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)
*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision. Source: APA 2013

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
It Can Happen to Anyone

https://youtu.be/Pet6ugDj8CY

https://youtu.be/DbeVhMye9NQ

https://youtu.be/6NBNKvYSWPo

https://youtu.be/KtZLioQglys
Prescribing Practices

In 2012, providers wrote 259 million prescriptions for opioids

- More than enough for every American adult to have a bottle of pills
- 20% of those with a pain-related diagnosis, acute or chronic, receive an opioid prescription
- Opioid prescriptions:
  - Have a place in pain management when used appropriately
  - Can lead to OUD

Source: [https://www.cdc.gov/vitalsigns/opioid-prescribing/](https://www.cdc.gov/vitalsigns/opioid-prescribing/)

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Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2012-2013

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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The drug-related death rate for women is 8.7 per every 100,000 people and 22 per 100,000 people for men. In both, the number of drug deaths have grown considerably – a 48% increase from 2010-2015 for women and an 83% increase for men.

### Drug Deaths by Sex in New York State 2010-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Female</th>
<th>Male</th>
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<tbody>
<tr>
<td>2010</td>
<td>601</td>
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<tr>
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<td>826</td>
<td>1,684</td>
</tr>
<tr>
<td>2015</td>
<td>891</td>
<td>2,118</td>
</tr>
</tbody>
</table>


New York State Opioid-Related Deaths

New York State overdose deaths involving any opioid, crude rate per 100,000 population

Source: https://www.health.ny.gov/statistics/opioid/
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
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Screening vs. Testing

Screening based only on factors such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases and may add to stereotyping and stigma. Therefore, it is essential that screening be universal with a validated verbal tool.

A positive biochemical drug test result is not in itself diagnostic of OUD or its severity.

- Urine drug testing only assesses for current or recent substance use; therefore, a negative test does not rule out sporadic substance use. Also, urine toxicology testing may not detect many substances, including some synthetic opioids, some benzodiazepines, and designer drugs.


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Urine Toxicology

Urine drug testing has been used to detect or confirm suspected opioid use, but should be performed only with the patient’s consent and in compliance with state laws. Pregnant women should be informed of the potential ramifications of a positive test result, including any mandatory reporting requirements.

Limitations of urine toxicology:
- Typically does not test for alcohol or tobacco use
- Potential for false positive and false negative results
- Increases risk for possible child welfare involvement
- Test results do not assess parenting capabilities
- Often applied selectively
- Lab cut-off points for sensitivity

Sources:
ACOG. Opioid Use and Opioid Use Disorder in Pregnancy. Opinion No. 711.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
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Assess all pregnant women for SUDs.

- Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman.
- Early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment (SBIRT) of pregnant women with OUD improve maternal and infant outcomes and should be incorporated into the maternity care setting. (see appendix, slides 65-70 for screening tools)

Who can perform SBIRT?
Physicians, nurse practitioners, licensed midwives, physician assistants, nurses, health or substance use counselors, prevention specialists, and other health or behavioral health staff.


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Obstetric Care for Women with Opioid Use Disorder

**READINESS BUNDLE**

- Provide education to promote understanding of opioid use disorder (OUD) as a chronic disease.
- Emphasize that substance use disorders (SUDs) are chronic medical conditions, treatment is available, family and peer support is necessary and recovery is possible.
- Emphasize that opioid pharmacotherapy (i.e., methadone, buprenorphine) and behavioral therapy are effective treatments for OUD.
- Provide education regarding neonatal abstinence syndrome (NAS) and newborn care.
- Awareness of the signs and symptoms of NAS
- Interventions to decrease NAS severity (e.g., breastfeeding, smoking cessation)
- Engage appropriate partners (i.e., social workers, case managers) to assist patients and families in the development of a “plan of safe care” for mom and baby.

Every provider/clinical setting

- Provide staff-wide (clinical and non-clinical staff) education on SUDs.
- Emphasize that SUDs are chronic medical conditions that can be treated.
- Emphasize that stigma, bias and discrimination negatively impact pregnant women with OUD and their ability to receive high quality care.
- Provide training regarding trauma-informed care.
- Establish specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers.
- Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.
- Know state reporting guidelines regarding the use of opioid pharmacotherapy and identification of illicit substance use during pregnancy.

**RECOGNITION & PREVENTION**

Every provider/clinical setting

- Assess all pregnant women for SUDs.
- Utilize validated screening tools to identify drug and alcohol use.
- Incorporate a screening, brief intervention and referral to treatment (SBIRT) approach in the maternity care setting.
- Ensure screening for poly-substance use among women with OUD.
- Screen and evaluate all pregnant women with OUD for commonly occurring co-morbidities.
- Ensure the ability to screen for infectious disease (e.g., HIV, Hepatitis and sexually transmitted infections (STIs)).
- Ensure the ability to screen for psychiatric disorders, physical and sexual violence.
- Provide resources and interventions for smoking cessation.
- Match treatment response to each woman’s stage of recovery and/or readiness to change.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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READINESS
(Every Patient / Family)
Readiness

• Stigma/bias/discrimination
• Chronic disease
• Treatment
• Education
• Family/patient engagement
• Care coordination
• Multidisciplinary care coordination
• Antenatal, intrapartum, postpartum planning
• Pain control
• Know guidelines and statutes
• Know best resources
Enhance Patient & Family Engagement

Provide education to promote understanding of OUD as a chronic disease.

- Engage the patient, her partner, family, or other support (if she desires) early in the process and care plan.
- Encourage the patient to describe the dynamics of her support network and identify who she would like to participate in her care.
- Create a bundle (toolkit) to assist with patient and family engagement and to help manage the patient’s expectations such as:
  - Am I hurting my baby?
  - Is Medication-assisted treatment (MAT) safe for my baby?
  - Will my baby be taken away from me if I am using? Are there issues with specific drugs?
  - Breastfeeding recommendations – refer to ACOG guidelines
  - What is Neonatal Abstinence Syndrome (NAS) and what are the long-term effects of NAS? (see appendix, slide 73 for NAS resources)
  - What is the role of child protective services (CPS) and what requires a notification or a report to CPS? (see appendix, slide 83- CAPTA flowchart)
Enhance Patient & Family Engagement

- Utilize motivational interviewing techniques, include trauma-informed care, and communicate positive stories of people with OUD to engage the patient in her care (see appendix, slide 75 for SAMHSA resource)
- Provide written information for the patient and her family that addresses her key concerns (assess patient health literacy to improve comprehension)
- Schedule a prenatal consultation with a neonatologist, NNP, MFM, or social worker to provide the patient facts about what happens at the particular institution or with the NICU to educate the patient and her family on the care of the baby following delivery, including discussion of:
  - Neonatal Assessment
  - Breastfeeding recommendations
  - The NAS scoring system tool – empower patient by reviewing components of assessment systems, discuss the limitations of the tool and strategies for engaging mother in the process
Reduce Stigma

Change perceptions of OUD through the use of a common language and emphasize that SUDs are chronic medical conditions that can be treated.

- Stigma, bias, and discrimination negatively impact pregnant women with OUD and their ability to receive high quality care.
- Strive to use language that helps reduce stigma, accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients. For example, replace “drug abuser” with “person with a substance use disorder” or “in recovery” rather than being “clean.”
- Develop tools to educate multidisciplinary teams of providers on the use of non-judgmental and harm-reduction focused language and learn how to acknowledge and change implicit biases of providers.

Engage all staff in training, including clinical, administrative, and all other office personnel.

Source: Drug Policy Alliance
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
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Words Matter

X Don’t Use
Dehumanizing, demeaning, demoralizing, language, such as:

- Addict
- Get clean, Clean drug test
- Crazy vs. “normal”

Use
People-first language that confers respect, such as:

- When speaking generally, say: person who uses drugs. When talking about a specific issue, say: person who has a problematic relationship with drugs.
- When referring to the newborn, they are not born addicted rather they have prenatal substance exposure.
- Stay away from this term, which implies that a person was previously “dirty.” Instead say: a person who formerly used drugs. When possible, ask the person directly how they refer to themselves and their journey. If referring to a test, say: test was negative, test was not positive for substance.
- Avoid using terms that refer to mental illness – unless that’s truly what’s being discussed. Instead: celebrate difference and diversity of experiences and approaches.

Words Matter

X Don’t Use
Dehumanizing, demeaning, demoralizing, language, such as:

Junkie, Crackhead, Zombie, Tweaker

“Those” people

Addicted baby

✓ Use
People-first language that confers respect, such as:

Do not use dehumanizing terms for people who use various substances – that contributes to the othering, stigmatizing, and discrimination of people who have needs. Instead say: person who uses injection drugs/crack cocaine/synthetic cannabinoids, if in fact it’s necessary to specify.

Don’t use “othering” language that draws false distinctions among people. Instead: use inclusive language and describe the group or individual using people-first language.

This label is not scientifically supported and leads to damaging stereotyping. Instead say: prenatal exposure to a controlled substance or opioid exposed newborn.

Source: Drug Policy Alliance
Neonatal Abstinence Syndrome (NAS)

Provide education regarding neonatal abstinence syndrome (NAS) and newborn care.

• Infants born to women who used opioids during pregnancy should be monitored by a pediatric care provider for neonatal abstinence syndrome (NAS), a drug withdrawal syndrome that opioid-exposed neonates may experience shortly after birth.
  • Engage patients early on in care and offer a consultation with MFM or pediatrics in their third trimester
  • Ensure awareness of the signs and symptoms of NAS
  • Include interventions to decrease NAS severity (eg, maternal-infant bonding and breastfeeding, and smoking cessation)
New York State neonatal abstinence syndrome (NAS) crude rate per 1,000 newborn discharges (any diagnosis)

Source: https://www.health.ny.gov/statistics/opioid/
New York State NAS by county

New York State neonatal abstinence syndrome crude rate per 1,000 newborn discharges (any diagnosis)

- Data not available
- 0 - < 8.0: Q1 & Q2
- 8.0 - < 10.8: Q3
- 10.8 +: Q4

Crude hospital discharge rate
Counties are shaded based on quartile distribution
(* Fewer than 10 events in the numerator, therefore the rate is unstable)

Definition: Newborn with withdrawal syndrome or affected by narcotics via placenta or breast milk.

Source: 2012-2014 SPARCS Data as of September 2016
~ The SPARCS data do not include visits/discharges by people who sought care from hospitals outside of NYS, which may lower numbers and rates for some counties, care from hospitals especially those which border other states.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
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NAS: Signs to Watch For

- Increased muscle tone “tightness”
- Poor eating or vomiting. Often, babies look like they want to eat, but they are not able to suck and swallow at the same time
- High pitched or long periods of crying or fussiness
- Trouble sleeping. Without enough sleep, they are not able to eat properly.
- Tremors or shaking
- Diarrhea. This may cause the baby to lose weight.
- Fever or sweating
- Frequent yawning or sneezing
- Difficulty breathing because of a stuffy nose, fast breathing, or forgetting to breathe
- Breakdown of skin on face or knees because of rubbing on the linen
- Possible seizures

*Use a modified NAS scoring system (eg, Finnegan’s)*
Plan of Safe Care

Develop a network of providers (eg, social workers, case managers, legal services if available) to assist patients and families in the development of a “plan of safe care” for mom and baby (see appendix, slide 76 for plan of safe care resources).

- Develop patient-specific care plans to enhance communication among treating providers that detail prenatal, labor and delivery, postpartum, and newborn care as well as a plan of safe care after hospital discharge.
  - Representatives from all disciplines who interact with the patient should be engaged in development of the plan, including obstetrics, pediatrics, neonatology, patient advocates, behavioral health, social worker/case managers, anesthesiology, and addiction.
  - Identify a case manager to oversee transition of the patient.
  - Hold regular meetings to review cases and coordinate care management.
Plan of Safe Care

Understand “Plan of Safe Care” requirements.

- Child Abuse Prevention and Treatment Act (CAPTA) (see appendix, slide 83 for resources)
- Talk with mom to ensure she has thought about safe care for herself and her baby after delivery
  - Ensure access and referral to support in the community for breastfeeding, postpartum care (including depression screening and family planning), and social services following release from health care providers
- Address the health and substance use disorder treatment needs of the baby and family
- Ensure mom has a plan for continuity of care post-delivery – a safe house to care for her baby, MAT, crib, car seat, etc.
READINESS
(Every Outpatient Clinical Setting/Health System)
Professional Education

Provide staff-wide (clinical and non-clinical staff) education on SUDs.

- Recognize that pregnancy is a great window of opportunity to identify and treat women with OUD and improve maternal and infant outcomes
- What is OUD and who is affected (universal terminology and definitions for common language)?
- Offer strategies to engage the patient and how to overcome barriers
- What medications are appropriate during pregnancy?
- Medication-assisted treatment (MAT): methadone vs. buprenorphine (ie, Subutex/Suboxone) regimens – and accept patients who are NOT willing to take the treatment
  - Interactions with other medications may synergize opioids

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Professional Education

• Ensure providers and the obstetric team are educated on safe opioid prescribing practices

• Harm reduction interventions/programs (eg, naloxone distribution and syringe exchanges) for patients

• Appropriate levels of treatment maintained throughout the delivery

• Collaborate with the pediatric provider in the solution and in developing a newborn management plan

• Identify community resources with which to partner (eg, agencies that treat SUD, domestic violence shelters, WIC, home visiting agencies, etc.)
Practice Approach

Practices should **clearly define** the approach to screening and testing pregnant patients for opioid use based on what best aligns with their resources, expertise, and capacity.

- An important first step all practices should initiate is mapping of local resources such as identifying available treatment centers for pregnant women and locating buprenorphine prescribing providers.
  - Educate **ALL** staff on the practice approach and why you are screening, explain the reasons (eg, identify patients early on for care, next steps, NICU stay, etc.)
  - Explain to staff why withdrawing a mom while pregnant is not optimal
What is our philosophy of caring for and treating pregnant patients with OUD?

Following a positive screen or disclosure of probable OUD

Patient readiness to engage in treatment (if not ready initially, provide relevant, non-judgmental educational materials and/or schedule another appointment in a short interval to develop trust)

Full range of patient care offered at practice (prenatal care and MAT)

Prenatal care only referred out co-managed for MAT

Refer patient out for all needed services (patient discharged)

Signs of acute withdrawal?

Go to ER, consider in-patient stabilization or referral to experienced addiction provider

Patient linked to mental health, chemical dependency and social (eg, housing, transportation, WIC etc.) services.

• Referral to experienced MAT provider (office-based buprenorphine or opioid treatment program (OTP))
• Patient consents to coordinate treatment plans
Practice Education: Patient Encounters

• Ensure office staff are knowledgeable about patient education, MAT, available opioid treatment programs and the potential impact on the fetus *(see appendix, slide 72 for resources)*
  
  • This may include coordinating a meet and greet with a pediatrician and ensuring an appointment is scheduled prior to delivery, connecting the patient to community-based services (eg, mental health services).

• Discuss the importance of trauma-informed care and an environment of open communication *(see appendix, slide 78 for trauma-informed care resource)*
Trauma-Informed Care

Provide training regarding trauma-informed care to your staff.

*It is important that the staff who use motivational interviewing, recognize trauma-informed care as an element in the tapestry of a woman’s life.

- Understand the neurobiology of trauma
- Recognize the signs and symptoms of trauma in patients and families
- Screen for physical and sexual violence (eg, use ACES screening 10 question as a guide (see appendix, slide 78 for example)
- Coordinate care with behavioral health/psychiatric care teams
- Prevent re-traumatization
- Seek someone in the community to educate your staff on trauma-informed care, read articles and books, and recognize cues to help where staff need to go with questions.
  
  - Attend trainings provided by crisis centers/universities

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018
Becoming a MAT Provider

Buprenorphine Waiver Training:

- To prescribe or dispense buprenorphine, physicians must qualify and apply for a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000).

- **Physicians:** The DATA 2000 specifies training is necessary for physicians to obtain a waiver to engage in office-based treatment of opioid use disorders using drugs approved by the FDA on Schedules III, IV, and V.

- **Nurse Practitioners, Physician Assistants and Certified Nurse Midwives:** In July 2016, President Obama signed the Comprehensive Addiction and Recovery Act (CARA) into law. CARA authorizes qualified NPs, PAs, and CNMs to become waivered to prescribe buprenorphine in office-based settings for patients with OUD. ASAM, AANP, and AAPA are authorized by statute to provide this training.

*For alternatives to becoming a licensed treatment provider, go to www.buprenorphine.samhsa.gov. Click on "Data Physician Locator" under the "General" category. This will bring you to a listing of qualified physicians, which you can search by city, county or zip code.*
## Methadone vs. Buprenorphine in Pregnancy

<table>
<thead>
<tr>
<th>Methadone</th>
<th>Buprenorphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>• May have better treatment retention</td>
<td>• May have less severe NAS</td>
</tr>
<tr>
<td>• No risk of precipitating withdrawal (with initiation of therapy)</td>
<td>• Fewer drug interactions</td>
</tr>
<tr>
<td>• Treatment initiation may be easier</td>
<td>• Ability to be treated on an outpatient basis and does not require daily visits</td>
</tr>
<tr>
<td></td>
<td>• Reduced risk of overdose during induction</td>
</tr>
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Pain Management Strategies: Practice-Based

Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.

- Educate providers on strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacological, and non-opioid pharmacologic treatments.
  - Confirm dose of methadone or buprenorphine with women’s health care provider and with ISTOP/PMP.
- Ensure awareness of dosage needs throughout the phases of pregnancy including addressing pain medication with patients and appropriate hospital staff at delivery.
  - If the patient is in prolonged labor, she may need to use her maintenance therapy medications during labor.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Establish specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers (see appendix, slides 80-82).

- Help women’s health care providers obtain resources to become buprenorphine trained.
- Ensure pediatricians in the community are equipped with patient education about NAS and provide education about OUD.
- Educate emergency medicine physicians about the unique care plans for OUD in pregnant women and create protocols/processes for caring for this population when presenting to the ED (eg, care management/coordination through the development of algorithms/visual aids).
- Every hospital should standardize their discharge education and dosing for opioids (7 day supply limit).

Identify provider champions who can promote education and encourage other providers and systems to become engaged.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Establish Care Coordination

Ensure that OUD treatment programs meet patient and family resource needs (eg, wrap-around services such as housing, child care, transportation and home visitation).

- Identify a facilitator to train new staff, determine gaps in services, and bring teams together through hospital-based quality improvement programs.

- Seek out community health worker networks in your region.
Know federal (Child Abuse Prevention Treatment Act – CAPTA), state and county reporting guidelines for substance-exposed infants.

(see appendix, slide 83 CAPTA notification)

- Know what the delivering hospital policy is regarding testing, contacting Child Protective Services (CPS), and the expected length of stay
- Know state, legal and regulatory requirements for SUD care

For example:

- Pregnant women have priority (SABG Block Grant Requirements)
- Treatment providers must ensure timely access to treatment services for pregnant women
- Providers of treatment services must establish a policy to offer admission preference to substance abusers who inject drugs intravenously or are pregnant
RECOGNITION
(Every Provider/Clinical Setting)
Recognition

- Assess ALL
- SBIRT
- Polysubstance use
- Co-morbidities
- Psychiatric disorders
- Intimate Partner Violence (IPV)
- Smoking
- Readiness to change
Screen and evaluate all pregnant women with OUD for commonly occurring co-morbidities including psychiatric disorders, and physical and sexual violence. Ensure the ability to screen for infectious disease (eg, HIV, hepatitis and sexually transmitted infections (STIs)).

Ensure screening for polusubstance use among women with OUD. Provide resources and interventions for smoking cessation.

- ALL women seen in the office, in-patient or emergency/urgent care should be screened for drug, alcohol and all forms of nicotine use utilizing a selected SBIRT tool (refer back to slide 16-17 screening vs. testing as well as appendix, slides 65-68 for specific screening tools)
OUD Screening Tools

Utilize validated screening tools to identify drug and alcohol use.

- Routine screening should rely on validated screening tools, such as questionnaires like the 4Ps, Audit-C, NIDA Quick Screen, and CRAFFT (for women 26 years or younger)
  - All practices should use a screening tool that is non-judgmental, open-ended and implemented by their practice (see appendix, slides 65-68)
  - Patients may be more receptive to provider questioning while others may prefer a self-assessment on paper.
  - Screening is recommended at the first encounter. Elements can be added to the EMR under the flowsheet and flagged as a reminder to ask about substance use again in the third trimester.
  - In hospital screening – H&P should document what screening tool was used and that it was performed with the patient alone (away from family). Training should emphasize documentation that is non judgmental not allowing for statements like “non-contributory”.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Brief Intervention

• Patients who screen positive for OUD in pregnancy should receive a brief intervention. This intervention should use principles of motivational interviewing to affect behavioral change (see appendix, slide 75)

• Effective brief intervention includes 3 steps:
  1. Offer feedback
  2. Listen and understand the patient’s motivation (eg, “I hear that you use x to deal with stress of life at home”)
  3. Explore other options to address patient’s motivation for substance use (eg, “Are there other ways to deal with stress in a more healthy way?”)

Note: providing written handouts to ALL women can reach those who are afraid to disclose use, but who may be at risk and need treatment


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018
Referral to Treatment

Match treatment response to each woman’s stage of recovery and/or readiness to change.

• Work with behavioral health/case managers in-office (if available) to assist with the intervention component of SBIRT
• Make referrals as needed that facilitate access to treatment and related services for women who need these services
  • Make connections with treatment providers to build relationships
  • Communicate with MAT providers at least once a month
• Ensure support for women’s health care providers starting buprenorphine waiver training or newly trained (see appendix, slide 40)
READINESS
(Every Inpatient Clinical Setting/Health System)

Understanding Your Hospital Approach/Philosophy
Regional Perinatal Center (RPC) & Hospital Education

- Engage community resources - ensure that all agencies are involved in the community – create resource guides, etc.
- All hospital teams should be trained in trauma-informed care, substance use disorders, opioid use disorder, safe care plan, etc. (*see appendix for examples*).
- Facilitate discussions with childbirth educator, obstetric provider (ob-gyn or licensed midwife), pediatric provider or neonatologist, anesthesiologist, and social worker to establish a plan and clarity of approach to care.
- Understand the hospital policy/approach for evaluating newborns for substance exposure at the time of delivery.
- The ob-gyn provider should know the basic discharge criteria for the at risk newborn.
Hospital Approach

• Ensure all health care providers involved in the care of the woman have an understanding of the federal reporting requirements of CAPTA/CARA. Provide education where needed.

• Nursing
• Social Worker
• Women’s Health Care Provider including ob-gyn, midwife, hospitalist, resident, medical and nursing students

• Anesthesiologists
• Neonatologists
• Behavioral Health Specialists
• Emergency Department
Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.

• Each hospital is encouraged to develop guidelines for management of patients with OUD.

• Patients with OUD may experience more pain (increased sensitivity) and require higher doses of opioids (tolerance).

• As appropriate, maximize non-pharmacologic therapies (eg, PT) and non-opioid pharmacologic treatments (eg, NSAIDS). Avoid mixed agonist-antagonists.

• Share ‘withdrawal” order set for pregnancy patients (include anesthesia, pharmacy, OBs, and neonatologists/pediatricians) (see slide 79 for sample order set)
Medical Care

Evaluation and management avoiding bias from patient’s history of OUD and/or pregnancy.

Tx: Yes. Verify MAT dose/frequency. Avoid changes unless medically necessary and in consult with MAT provider.

Tx: No. Assess willingness to engage in treatment and refer

1. Women with OUD are as (or more) susceptible to medical conditions
2. Pregnancy may alter the presentation of common medical conditions
3. Pregnancy is not a contraindication to appropriate evaluation or opioid pain management

Prenatal care

Assess for prenatal care

PNC: Yes. Update provider

PNC: No. Refer for prenatal care

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018
Pain Management: Intrapartum

- Intrapartum analgesia needs are the same as for any other woman
  - It should not be assumed that MAT is sufficient for intrapartum analgesia
- Methadone or buprenorphine should be continued throughout labor
  - Buprenorphine should not be temporarily stopped in anticipation of delivery
  - MAT should not be used/adjusted for intrapartum analgesia
- IV access may be more difficult
- Neuraxial anesthesia is safe
  - The incidence of hypotension may be increased in the presence of some co-morbid health conditions (eg, liver disease)
- Avoid mixed agonist-antagonists
Pain Management: Postpartum

Reassure the patient that their pain will be addressed. Medications for MAT should not be assumed to cover postpartum pain or adjusted/interrupted for pain management.

- **Vaginal delivery:** Non-opioid analgesics are often adequate
- **Cesarean delivery:** Patients often experience more pain and require higher than average opioid doses
- It is **impossible** to predict a patient’s pain level or opioid need
- Maximize nonpharmacological (eg, heat) and non-opioid pain management (eg, TAP block, Toradol); double concentration patient-controlled analgesia (PCA)
  - Consider scheduled, rather than PRN, medications
  - Avoid agonist/antagonists and full antagonists.

Breastfeeding should be encouraged for women who are on a stable dose of methadone or buprenorphine, interested, and have no other contraindications.
Withdrawal/Overdose

Assess severity of symptoms using a Clinical Opiate Withdrawal Scale (COWS) (see appendix, slide 84)

Naloxone for respiratory depression/maternal overdose

antihistamines, alpha agonists, benzodiazepines, and opioid replacement

Can continue prescribed methadone or buprenorphine but cannot initiate treatment without waiver approval

Symptomatic management

Consult Addiction Medicine
Treatment Services

Identify local SUD treatment facilities that provide women-centered care.
Ensure that drug and alcohol counseling and/or behavioral health services are provided.

- Create better engagement and communication among providers within the continuum of care and across service areas, including the justice system, as needed
- Educate all providers of the importance of universal screening and have resources available for those screening positive (see appendix, slides 85-86 for NYS OASAS live dashboard https://findaddictiontreatment.ny.gov or call HOPEline 877.846.7369)
- Contact local counties for a list of Substance Use Disorder Treatment Referral/Provider Directory (provide name of the contact by County)
- Use of the Medicaid Cab program to schedule (five day advance notice) visits even if it brings patients two hours away from RPC and ensure Medicaid cab companies are involved in the solution
Conclusion

• Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman.
• It is vital to use language that helps reduce stigma, accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients.
• Specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers should be established.
• Various resources exist, including those listed in the attached appendix.
ACOG District II Opioid Use Disorder in Pregnancy
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Ellie Ward

- Alliance for Innovation on Maternal Health (AIM)
- HANYS’ Statewide Opioid Addiction Prevention and Management Collaborative
- NYSDOH AIDS Institute, Office of Drug User Health
- NYSDOH’s New York State Perinatal Quality Collaborative (NYSPQC)
- NYS Office of Alcoholism and Substance Abuse Services (OASAS)
Contact ACOG District II

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APPENDIX

The resources provided in this section are for informational purposes only. The exclusion of a resource, program or website does not reflect the quality of that resource, program or website. Note: websites and URLs are subject to change without advance notice.
Resources: Screening Tools

**4 Ps**

Parents: Did any of your parents have a problem with alcohol or other drug use?
Partner: Does your partner have a problem with alcohol or drug use?
Past: in the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
Present: In the past month, have you drank any alcohol or used other drugs?

Scoring: Two or more positive items indicates the need for further assessment

**CRAFFT – Substance Abuse Screen for Adolescents & Young Adults**

C Have you ever ridden in a CAR driven by someone (including self) who was high or had been using alcohol or drugs?
R Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
A Do you ever use alcohol or drugs while you are by yourself or ALONE?
F Do you ever FORGET things you did while using alcohol or drugs?
F Do your FAMILY or friends ever tell you that you should cut down on your drinking or drug use?
T Have you ever gotten in TROUBLE while you were using alcohol or drugs?

Scoring: Two or more positive items indicates the need for further assessment


STEP 1 – Ask the NIDA Quick Screen Question

Instructions: Using the sample language below, introduce yourself to your patient, then ask about past year drug use, using the NIDA Quick Screen. For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

Introduction (Please read to patient)

Hi, I’m __________, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Source: https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf
Resources: Screening Tools

**Quick Screen Question:**

*In the past year, how often have you used the following substances?*

- **Alcohol**
  - For men, 5 or more drinks a day
  - For women, 4 or more drinks a day

- **Tobacco Products**

- **Prescription Drugs for Non-Medical Reasons**

- **Illegal Drugs**

**STEP 2 - Ask about any lifetime drug use (Question 1)**

**Instructions:** Now ask the patient about any *lifetime* drug use. This form may be completed by your patient or any health care professional in your office. Screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed.

<table>
<thead>
<tr>
<th>Q1. In your <em>LIFETIME</em>, which of the following substances have you ever used?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cannabis (marijuana, pot, grass, hash, etc.)</td>
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<td>b. Cocaine (coke, crack, etc.)</td>
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<td>c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)</td>
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<td>d. Methamphetamine (speed, crystal meth, ice, etc.)</td>
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<tr>
<td>e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)</td>
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<tr>
<td>f. Sedatives or sleeping pills (Valium, Serapex, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)</td>
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<tr>
<td>g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)</td>
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<tr>
<td>h. Street opioids (heroin, opium, etc.)</td>
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<td></td>
</tr>
<tr>
<td>i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)</td>
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</tr>
</tbody>
</table>
  - Please record *nonmedical use only*: Non-medical use refers to using a
  substance either not prescribed to the patient or used in ways or amounts not
  prescribed by their doctor.
| j. Other – specify: | | |

Source: https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018
Resources: Screening Tools

Exhibit 2-2. SBIRT Process

Screening

- No or Low Risk
  - No Further Intervention
- Moderate Risk
  - Brief Intervention
- Moderate to High Risk
  - Brief Treatment (onsite or via referral)
- Severe Risk, Dependence
  - Referral to Specialty Treatment

Source: https://www.integration.samhsa.gov/sbirt/TAP33.pdf
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
## Resources: Reimbursement for SBIRT

<table>
<thead>
<tr>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Commercial Insurance, Medicaid</td>
<td>99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min</td>
</tr>
<tr>
<td>Commercial Insurance, Medicaid</td>
<td>99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min</td>
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<tr>
<td>Medicare</td>
<td>G0397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min</td>
</tr>
</tbody>
</table>

Source: [https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf](https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf)

## Resources: Reimbursement for SBIRT

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<th>Plan</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Medicaid</td>
<td>H0049</td>
<td>Alcohol and/or drug screening (code not widely used)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>H0050</td>
<td>Alcohol and/or drug service, brief intervention, per 15 min (code not widely used)</td>
</tr>
</tbody>
</table>

Source: [https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf](https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf)
Resources: Patient Education

Risks of continued SUD in Pregnancy:

Benefits of Medication-assisted treatment (MAT) in pregnancy with methadone and buprenorphine:
https://www.samhsa.gov/medication-assisted-treatment

Safety of the newborn, developing a plan of safe care for mother and newborn:

https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy

Neonatal Abstinence Syndrome: What You Need to Know:

Breast feeding - ABM Clinical Protocol #21: Guidelines for Breastfeeding and the Drug-Dependent Woman
Resources: Patient Education

Are you taking any of these prescription painkillers?

These are prescription painkillers called opioids and some of their brand names. If you take an opioid during pregnancy, it can cause serious problems for your baby.

- Buprenorphine (Suboxone®, Buprenex®, Butrans®, Priozine®)
- Codeine
- Fentanyl (Actiq®, Duragesic®, Sublimaze®)
- Hydrocodone (Lorcet®, Lortab®, Norco®, Vicodin®)
- Hydrocodone/Dilaudid®, Enfrego®
- Mepedone (Demerol®)
- Methadone (Dolophine®, Methadose®)
- Morphine (Actherane®, Avinex®, Darvon®, Benedryl®)
- Oxycodone (Oxycodone®, Percocet®, Percodan®)
- Oxydren (Oxapine®)
- Tramadol (ConZip®, Ayd®, Ultram®)

The illegal drug heroin is an opioid. Fentanyl and other prescription opioids are all being made and sold illegally.

Your provider may prescribe an opioid for you if you’ve been injured or had surgery. Opioids can be dangerous and addictive. They can cause problems for a baby in the early weeks of pregnancy, even before you know you’re pregnant.

If you take opioids during pregnancy, your baby can be exposed to them in the womb and go through withdrawal after birth. This is called neonatal abstinence syndrome or NAS. Even if you use an opioid only like your provider says to, it still may cause NAS in your baby.

If you’re pregnant and using opioids:

- Don’t start or stop taking any opioid until you talk to your health care provider. Switching to stopping certain medicaments can be harmful to you and your baby.
- Question suddenness (called sudden onset) can cause severe problems for your baby, including death.
- Tell your prenatal care provider about any opioid or other medicine you take, even if it’s prescribed by another health care provider.
- If you go to a provider who prescribes you an opioid, make sure the one you’re pregnant.
- Ask your provider about other kinds of painkillers you can take instead of opioids.

If you’re not pregnant and you’re using opioids:

- Use effective birth control until you’ve stopped taking the opioid.
- Talk to your provider about taking a safe pain medicine.

Watch a video about prescription medication: marchofdimes.org/prescriptionmeds

PREGNANCY:
Methadone and Buprenorphine

Some women are surprised to learn they get pregnant while using heroin, Oxycodone, Percocet or other pain medications that can be released (known as opioid drugs). You along with family and friends may worry about your drug use and if it could affect your baby.

Some women may want to "detox" as a way to stop using heroin or pain medications. Unfortunately, studies have shown that 8 out of 10 women return to drug use by a month after "detox." Therefore, most doctors treat opioid misuse by pregnant women with either methadone or buprenorphine. These are long-acting opiod medications that are associated with improved outcomes in pregnancy.

HOW CAN I GET STARTED ON METHADONE OR SUPERNOPHINE?

Detoxing when you live, there may be a special program that offers care to pregnant women who need methadone or buprenorphine. These programs can offer prenatal care and substance use counseling along with your medication.

Methadone may only be given by specially trained clinicians while buprenorphine may also be available from your primary care physician or obstetrician if they have received special training.

Some women will prefer or benefit from starting these medications while in a residential (inpatient) treatment facility.

WHAT IS THE BEST DOSE OF METHADONE OR SUPERNOPHINE DURING AND AFTER PREGNANCY?

There is no "best" dose of either medication in pregnancy. Every woman should take the dose of methadone or buprenorphine that is right for her.

The "right" dose will prevent withdrawal symptoms without making you too tired.

The right dose depends on how your body processes the medications.

In pregnancy, you process these medications more quickly, especially in the last several months. As this affects what dose you need.

The dose of methadone usually needs to increase with pregnancy — especially in the third trimester and you may need to take methadone more than once a day.

There is less known about buprenorphine dose changes in pregnancy, but increases may be necessary.

The dose does not seem to determine how much NAS a baby will have.

After delivery, the methadone or buprenorphine dose may remain the same or decrease as your body returns to its non-pregnant state. This can take up to a few months after delivery.

Your dose should be reduced if it begins to cause concern. Be sure to discuss whether you are feeling too sleepy with your doctors, nurses, and counselors. For further information please see brochure Children, breastfeeding and later care: Methadone and Buprenorphine.

Sources:

ACOG District II 2018
Resources: Patient Education

Neonatal Abstinence Syndrome

“Too often we underestimate the power of touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring. All of which have the potential to turn a life around.”

— Leo F. Buscaglia

Sources: Catholic Health Women Care
National Perinatal Association

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018
Resources: Provider Tools – NAS Scoring

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<td></td>
<td>Fever &gt; 39.3°C (101°F)</td>
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<tr>
<td></td>
<td>Frequent Yawning (&gt; 3-4 times/interval)</td>
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<td></td>
<td>Mutilting</td>
<td>1</td>
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<tr>
<td></td>
<td>Nasal Stiffness</td>
<td>1</td>
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<td></td>
<td>Sneezing (&gt; 3-4 times/interval)</td>
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<td></td>
<td>Nasal Flaring</td>
<td>2</td>
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<tr>
<td></td>
<td>Respiratory Rate &gt; 60/min</td>
<td>1</td>
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<td></td>
<td>Respiratory Rate &gt; 60/min with Retractions</td>
<td>2</td>
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<tr>
<td>GASTROINTESTINAL</td>
<td>Excessive Sucking</td>
<td>1</td>
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<tr>
<td>DISTURBANCES</td>
<td>Poor Feeding</td>
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<td>Regurgitation</td>
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<tr>
<td></td>
<td>Projectile Vomiting</td>
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<tr>
<td></td>
<td>Loose Stools</td>
<td>2</td>
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<tr>
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<td>Watery Stools</td>
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**SUMMARY**

<table>
<thead>
<tr>
<th>TOTAL SCORE</th>
<th>SCORER’S INITIALS</th>
<th>STATUS OF THERAPY</th>
</tr>
</thead>
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<td></td>
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</table>


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018

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Motivational Interviewing: Motivational interviewing is a therapeutic style intended to help clinicians work with clients to address their ambivalence. While conducting a motivational interview, the clinician is directive yet client centered, with a clear goal of eliciting self-motivational statements and behavioral change from the client, and seeking to create client discrepancy to enhance motivation for positive change.
Resources Providers: Plan of Safe Care

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
PLAN OF SAFE CARE

<table>
<thead>
<tr>
<th>Name of Infant</th>
<th>DOB</th>
<th>Admission date</th>
<th>Discharge date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Individual developing PDSG</th>
<th>Individual monitoring PDSG</th>
</tr>
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<table>
<thead>
<tr>
<th>Phone</th>
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<table>
<thead>
<tr>
<th>Email</th>
<th>Email</th>
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</table>

Household Members and Affected Family or Caregivers of the Infant:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to Infant</th>
<th>Name</th>
<th>Age</th>
<th>Relationship to Infant</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Post-Discharge Family Strengths and Goals: (e.g., breastfeeding, housing, smoking cessation, parenting support, recovery)

<p>| |</p>
<table>
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Identified Supports: (e.g., stable living environment, family and friends, employment, etc.)

<p>| |</p>
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Safety Factors and Protective Factors Present: (e.g., parental resilience, social connectedness, knowledge of parenting and child development, social and emotional competence of children, etc.)

<p>| |</p>
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</table>

Family is Currently Involved in the Following Services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Organization</th>
<th>Contact person/Phone/Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

New Family Services Referred or Recommended:

<table>
<thead>
<tr>
<th>Service (indicate referred or recommended)</th>
<th>Organization</th>
<th>Contact person/Phone/Email</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Plan of Safe Care (PDSG)

Comments: 

<p>| |</p>
<table>
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<tr>
<th></th>
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</table>

Signature of parent/caregiver:

<table>
<thead>
<tr>
<th>Date</th>
<th>Print name</th>
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Signature of staff:

<table>
<thead>
<tr>
<th>Date</th>
<th>Print name</th>
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Review by (Date): 

<table>
<thead>
<tr>
<th>Date</th>
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</table>
Perinatal networks can serve as a valuable community resource:

- Knowledge of local programs that a woman can utilize for various medical and social needs.
- May have home visiting programs or can provide a warm connection.
- Serve as a maternal child health resource referral network.
- Referral to community connections and with the employ of Community Health Workers (CHW)
  - CHW’s can help identify other community resources that might come up such as WIC, SNAP, childcare, parenting etc.
- Follow up after a direct referral for more information about support services.
Resources: Provider Tools – Trauma Informed Care

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often …
   - Swear at you, insult you, put you down, or humiliate you?
   - Act in a way that made you afraid that you might be physically hurt?
   - Yes No
   If yes enter 1 ______

2. Did a parent or other adult in the household often …
   - Push, grab, slap, or throw something at you?
   - Ever hit you so hard that you had marks or were injured?
   - Yes No
   If yes enter 1 ______

3. Did an adult or person at least 5 years older than you ever …
   - Touch or fondle you or have you touch their body in a sexual way?
   - Try to or actually have oral, anal, or vaginal sex with you?
   - Yes No
   If yes enter 1 ______

4. Did you often feel that …
   - No one in your family loved you or thought you were important or special?
   - Your family didn’t look out for each other, feel close to each other, or support each other?
   - Yes No
   If yes enter 1 ______

5. Did you often feel that …
   - You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   - Yes No
   If yes enter 1 ______

Source: https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018
## Resources: Provider Tools – Withdrawal Order Set

### Withdrawal Order Set

**PO**

**VITALS**

**Airway, Breathing, Circulation**

**INDICATE MEDICATION AND IV ORDERS**

### Alcohol Withdrawal Orders

**PO**

- Vitamin B6, 10 mg
- Folic Acid, 5 mg
- Multivitamin, 10 mg
- Magnesium, 1 gram
- Glucose, 50 grams
- Hydrocortisone, 50 mg
- Naloxone, 0.4 mg IV
- Nalbuphine, 0.5 mg IM

**IV**

- Thiamine, 500 mg
- Folic Acid, 5 mg
- Naloxone, 0.4 mg IV
- Nalbuphine, 0.5 mg IM
- Magnesium, 1 gram

**NON-MEDICATION ORDERS**

- labs: CBC, Comprehensive Metabolite Panel, Urea, Drug screen
- urine dipstick
- propranolol IV

**NURSING ORDERS**

- height and weight on admission
- K-pod

**COMMENTS**

- COWS scale & GVS for alcohol withdrawal
- Naloxone 0.4 mg IV q15m, titrate
- Opiate withdrawal
- Multivitamin, 10 mg IM q24h
- Magnesium, 1 gram IM q12h
- Glucose, 50 grams IV q4h
- Hydrocortisone, 50 mg IV q6h
- Naloxone, 0.4 mg IV q2h
- Nalbuphine, 0.5 mg IM q2h

### COWS Withdrawal Order Set

- **COWS** (Cowan & Wells) scale & GVS for alcohol withdrawal
- **GVS** (Guthrie & Veleckis) scale & GVS for alcohol withdrawal
- **Naloxone** (0.4 mg IV q15m), titrate
- **Hydrocortisone** (50 mg IV q6h)
- **Nalbuphine** (0.5 mg IM q2h)

**SCD’s in All Antepartum Patients**

---

Source: Crouse Health Withdrawal Order Set


ACOG District II 2018
Resources: Provider Tools – Collaborative Approach

A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS

Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
ACOG District II 2018
Resources: Provider Tools

Figure 1: Sample Collaborative Process

1. Set the Stage for Collaboration
   - Establish the Collaborative Structure:
     - Steering Committee
     - Core Team
     - Facilitator
   - Understand:
     - Baseline resources, gaps and barriers
     - Partner mandates and priorities that can affect level of involvement
     - Broad areas of action and priority

2. Engage Key Stakeholders and Establish Work Groups
   - Assess:
     - Who is involved in the initiative?
     - What does each individual, organization or system contribute?
     - Who is missing?

3. Define Shared Goals
   - Examine:
     - System-specific policies, practices and values

4. Identify Strategies and Jointly Monitor Outcomes
   - Develop:
     - A work plan that details specific action steps by priority
     - Include timelines and outcome measures for each action step


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018
Resources: Provider

MOMS Care Coordination Model

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018
New York State
Child Abuse Prevention and Treatment Act (CAPTA) Requirements Related to Newborns Prenatally Affected by Substances

Delivery of Newborn

YES

Are there child protection concerns due to maternal substance use?*

NO

REPORT ACCEPTED BY STATEWIDE CENTRAL REGISTER

- A newborn or mother has a positive toxicology screen due to intrauterine exposure to:
  - illicit substances
  - prescription medication not prescribed to the patient
  - prescription medication not taken as prescribed.
- A newborn has withdrawal symptoms, or is diagnosed with neonatal abstinence syndrome (NAS) due to intrauterine exposure to:
  - illicit substances
  - prescription medication not prescribed to the patient
  - prescription medication that is not taken as prescribed.
- A newborn has been deemed by a health care provider to have Fetal Alcohol Spectrum Disorder (FASD).
- LDSS will engage family/caregiver in the development of a Plan of Safe Care for the affected infant and family/caregiver.

* For all other Child Abuse and Maltreatment concerns follow Mandated Reporter Protocol.

REPORT NOT ACCEPTED BY STATEWIDE CENTRAL REGISTER

Hospital staff are required to make a CAPTA notification to OCFS via the mailbox listed below for any of the following:

- The mother is in treatment for a substance use disorder and is being prescribed or administered an addiction medicine by a health care provider.
- The mother is under the care and treatment of health care provider for chronic pain and is taking opioids as prescribed.
- The mother is taking benzodiazepines as prescribed by health care provider.

A newborn has withdrawal symptoms, or is diagnosed with neonatal abstinence syndrome (NAS), due to intrauterine exposure to a prescription medication regimen being taken as directed by a health care provider.

Hospital staff will develop a Plan of Safe Care for the affected infant and family/caregiver.

Complete CAPTA Notification, scan and send via email to: ocfs.sm.SafeCareNotifications@ocfs.ny.gov
Clinical Opiate Withdrawal Scale (COWS)

| Patient’s Name: ______________________ | Date and Time __/__/__:________ |
| Reason for this assessment: ______________________ |

<table>
<thead>
<tr>
<th>Resting Pulse Rate: _______ beats/minute</th>
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<tbody>
<tr>
<td>Measured after patient is sitting or lying for one minute</td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GI Upset: over last 1/2 hour</th>
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<tbody>
<tr>
<td>0 no GI symptoms</td>
</tr>
<tr>
<td>1 stomach cramps</td>
</tr>
<tr>
<td>2 nausea or loose stool</td>
</tr>
<tr>
<td>3 vomiting or diarrhea</td>
</tr>
<tr>
<td>5 multiple episodes of diarrhea or vomiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sweating: over past 1/2 hour not accounted for by room temperature or patient activity.</th>
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<tbody>
<tr>
<td>0 no report of chills or flushing</td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
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<thead>
<tr>
<th>Tremor: observation of outstretched hands</th>
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</thead>
<tbody>
<tr>
<td>0 no tremor</td>
</tr>
<tr>
<td>1 tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>4 gross tremor or muscle twitching</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness: Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 able to sit still</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
</tr>
<tr>
<td>5 unable to sit still for more than a few seconds</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Yawning: Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no yawning</td>
</tr>
<tr>
<td>1 yawning once or twice during assessment</td>
</tr>
<tr>
<td>2 yawning three or more times during assessment</td>
</tr>
<tr>
<td>4 yawning several times/minute</td>
</tr>
</tbody>
</table>

Resources: Provider Directory

Sources: https://apps.oasas.ny.gov/reports_doc/TreatmentDirectory.pdf
https://oasas.ny.gov/providerDirectory/index.cfm
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
ACOG District II 2018
## Resources: Provider Directory

### New York State Office of Alcoholism and Substance Abuse Services
### Provider Directory

**County Name**: Albany

**Program Type - Service**: Crisis Services - Med Sup Withdrawal-Outpatient

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Peter’s Hospital City of Albany</td>
<td>315 S Manning Blvd, Albany, NY 12206</td>
<td>(518) 525-1003</td>
<td>9300G053197</td>
</tr>
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</table>

**Program Type - Service**: Crisis Services - Medical Managed Detoxification

<table>
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<tr>
<th>Provider Name</th>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Peter’s Hospital City of Albany</td>
<td>315 S Manning Blvd, Albany, NY 12206</td>
<td>(518) 525-1300</td>
<td>9300G050227</td>
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**Program Type - Service**: Gambling - Gambling Outpatient

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Counseling</td>
<td>650 Warren Street, Albany, NY 12208</td>
<td>(518) 462-6531</td>
<td>28330G02034</td>
</tr>
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</table>

**Program Type - Service**: Inpatient Treatment Services - Inpatient Rehabilitation

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Peter’s Hospital City of Albany</td>
<td>3 MercyCare Ln, Glens Falls, NY 12804</td>
<td>(518) 452-6745</td>
<td>9300G050139</td>
</tr>
</tbody>
</table>

**Program Type - Service**: Methadone Treatment - Medical Maintenance

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whitney M Young Jr Health Center, Inc.</td>
<td>10 DeWitt St, Albany, NY 12207</td>
<td>(518) 465-4771</td>
<td>36200G52011</td>
</tr>
</tbody>
</table>

**Program Type - Service**: Methadone Treatment - Methadone Clinic

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROMESA, Inc.</td>
<td>175 Central Ave, Albany, NY 12206</td>
<td>(518) 720-5659</td>
<td>00166G52795</td>
</tr>
</tbody>
</table>

**Program Type - Service**: Methadone Treatment - Methadone Clinic

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Program Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whitney M Young Jr Health Center, Inc.</td>
<td>10 DeWitt St, Albany, NY 12207</td>
<td>(518) 551-4894</td>
<td>35200G1631</td>
</tr>
</tbody>
</table>

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Sources: [https://apps.oasas.ny.gov/reports_doc/TreatmentDirectory.pdf](https://apps.oasas.ny.gov/reports_doc/TreatmentDirectory.pdf)

Resources: Medicaid Transportation Services

New York State Medicaid Cab Services

Currently the Department contracts with two Transportation Managers

• Medical Answering Services, LLC • All Counties North of NYC - https://www.medanswering.com (800) 850-5340 (24 hours a day, 7 days a week)

• LogistiCare Solutions, LLC

➢ New York City - http://www.nycmedicaidride.net (877) 564-5911 (24 hours a day, 7 days a week)
➢ Long Island - https://www.longislandmedicaidride.net (844) 678-1101 (24 hours a day, 7 days a week)

How Do Enrollees Get Transportation

• The medical provider or the enrollee contacts the appropriate transportation manager to request transportation:
  • The Department of Health’s policy requires 3 days notice for non-urgent trips. Every effort is made to assign trips made with less than 3 days notice, as available transportation options decrease as vendors shore up their daily trip rosters.
  • Urgent trips and hospital discharges are not subject to the 3 day window, and are considered priority.

• The transportation manager reviews the enrollee’s information to:
  • Ensure that the enrollee has appropriate Medicaid coverage
  • Assess the appropriateness of the request (i.e., is the request for transportation to a Medicaid-covered service?)
  • Assess the medically necessary mode of transportation
  • Verify enrollee’s address and suggested pick up time
  • Verify destination address, location within the facility, as well as time of appointment

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II 2018
Additional Resources

ACOG Maternal Opioid Bundle

ACOG Maternal Opioid Bundle Resource Listing

Buprenorphine Waiver Training Resources
• https://elearning.asam.org/products/the-asam-buprenorphine-course-acog-march-3-2017
• https://pcssnow.org/clinical-coaching/
• https://pcssnow.org/resources/

Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants
https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf

HANYS Opioid Addiction Prevention & Management Collaborative
https://www.hanys.org/quality/collaboratives_and_learning_networks/opioids/

Medications for OUD
https://store.samhsa.gov/shin/content/SMA18-5063FULLDOC/SMA18-5063FULLDOC.pdf

SBIRT
• http://bigsbirteducation.webs.com/addictionwebinars.htm
• https://www.integration.samhsa.gov/clinical-practice/sbirt#why
• http://www.sbirtoregon.org/

The Alcohol Use Disorders Identification Test (AUDIT)